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Subjunctive Grief: Affective Methodologies for Articulating Futures

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ABSTRACT Grief is typically portrayed as an individual experience that is a response to loss and provides the basis for personal growth; grief is something to work through, and, ideally, to benefit from, and represents a state change. But might it be possible to conceptualize grief of the future, a subjunctive grief that is based in speculation about change that brings that change into the present? The subjunctive invokes the wished for, the imagined, and the possible, and subjunctive grief serves to work through the experience of the future in the present. Focusing on debates around medical aid in dying and the parenting of a child with childhood psychosis, I consider grief in the subjunctive tense and how anticipation of change affects practices in the present. Attending to subjunctive grief provides an affective methodology that demonstrates interdependency and how conceptions of intimacy, love, and caregiving shape the experience of grief in the future tense.

KEYWORDS affect theory, death, future, kinship, mourning, psychoanalysis

Subjunctive grief is a way to conceptualize grieving the future and imagining the effects of possible futures. Subjunctive grief works through the current in disability studies that argues against "loss" as the precondition of disability, which often posits that a person once had a capacity and has lost it in some irreparable way.[1] Instead, disability studies scholars argue for various forms of difference and adaptation that push discussions of loss out of the frame and instead posit something akin to an appreciation for human plasticity, variation, and the ability for people to build sustainable ways of being in the world through interdependent communities.[2] Similarly, subjunctive grief is not predicated on loss but based

upon immanent and imminent—if unpredictable—change; it is based on the imaginary play of bringing the "what if?" into the present. In this way, subjunctive grief addresses something like the death of a loved one not simply because of death-as-loss, but also because death is a state change for a variety of other aspects of a still-living individual's life and relationships. How might the lives of my loved ones change in my absence? How might my life change in their absences? Subjunctive grief also addresses changes beyond our everyday intimacies and might be extended to the anxieties associated with climate change and the inevitable alterations to one's life as the climate unpredictably yet dependably mutates.[3] Dwelling with the subjunctive as the foundation for the inevitability of unpredictable change allows for the possibility that not all change is negative. Instead, change merely indexes the immanent flux of relations and the need for individuals and communities to recalibrate themselves to adapt to emergent conditions. The subjunctive pulls the speculative to the fore and asks for consideration of the connections between people and their worlds[4]—those connections that are marked as well as those that lie dormant until brought into the subjunctive frame.

Subjunctive grief imagines the possibilities of grief as motivational, as something that propels action rather than something that leads to dwelling in despair. The dwelling in grief is something that has long been associated with emotional experiences of loss, from Sigmund Freud's discussion of mourning and melancholia,[5] to Elizabeth Kubler-Ross's stages of grief,[6] to anthropological approaches to grief's social dynamics including Renato Rosaldo's discussion of grief and rage and Charles Briggs' attention to the performance of grief as a ritual enactment.[7] Grief is often posited as a process that an individual goes through, and when grief works—i.e., it is not pathological, leading to depression or ongoing distress—it moves an individual from one state to another; we change through our grief, becoming something other than what we were.[8]. Grief is also always social. It is something that is facilitated or not by the community that a person is a part of; grief connects community members through its ritual enactment and reveals

the connections between people and their world. A failure to do this social work of grieving can also lead to pathological forms of community, whether at the familial or societal levels;[9] a failure to properly grieve can leave individuals and communities in emotional states that metabolize their anger into interpersonal and institutional forms of violence. An avoidance or obfuscation of the mourning work that is to be done can lead to attachments to ways of life that are no longer sustainable due to changing economic and political conditions, as in the investment in "traditional" family structures and the perpetuation of structural inequities that expose some communities to risks that others are protected from.[10] Individually and collectively working through the "what if?" of changing lives and social conditions provides individuals and communities with the imaginative space to anticipate how life and society will change, and how their affective relations will change apace.

In conceiving subjunctive grief, I was motivated by a personal history of grief. After a period of illness associated with aging and Alzheimer's, my father died in 2013. During his illness, my partner and I had our first child, who arrived nearly seven weeks early and spent many of those weeks in the neonatal intensive care unit at the hospital where he was born. My maternal grandmother, with whom I was close, died after a fall down her basement stairs, and my cousin Richard, a veteran of the first Iraq War, died as a result of pancreatic cancer, one of many deaths associated with the suspected use of chemical warfare. It felt like a protracted season of grief, a sign that I had reached middle age, where the babies that were being born into my social world were being weighed against the adult deaths that were occurring at the same time. We moved across the country for new jobs, only to find that they were bad jobs and we lost friendships through the loss of regular contact with distant friends. We grieved for lives we lost through our relocation. We moved again, then again, picking up new relations along the way, knowing that we would lose them, which tinged them with the subjunctive: if that we could stay here with you, what life would we build together? Could we, in

the short term, build a version of that life, knowing that we would lose it—but also that it might live on through our distance and care?

Invoking the subjunctive is a way to work through how the wished for, the imagined, and the possible structure our everyday lives through speculation. In parallel to my conceptualization of the subjunctive and its relationship to grief, Jody Davies's recent work on the subjunctive in psychoanalytic practice points to the importance of the speculative in loving relationships.[11] Davies is writing specifically about "analytic love," the loving attachments that occur through transference and countertransference in the psychoanalytic encounter, where what is possible is limited by the structure of the relationship between analysand and analyst. Writing about a particularly challenging relationship with a client who demands motherly loving attention from Davies, she invokes the subjunctive as "'the would that I could' of the work":[12] if I could love you as your mother, I would, but I cannot because I am your analyst. The absence of this happening in reality, the absence of its actualization, allows for a playful space of speculation and possibility that provides room for the subjunctive to operate. She explains,

> this space can serve as a backdrop and container for a particular kind of analytic play and imagination. Because gratification need not be complete, the "make believe" can be experienced as fun and nurturing, and the offer of certain playful forms of gratification and nurturance need not give rise to the fear of emotional seduction and inevitable disappointment . . . . It is something that must be co-created between patient and analyst in a deeply mutual unfolding, like a spontaneous choreography, a pas de deux of point and counterpoint.[13]

In her relationship with the client who demands her love as a mother, they co-construct an imaginary cottage located along a stream and surrounded by wildflowers where they can love one another unproblematically. What if we were mother and daughter and lived in this cottage together, the subjunctive asks, and we were allowed to inhabit that shared emotional reality as a speculative practice? How might a similar use of the subjunctive—how will I live in the future?, how will

we be together then?—be employed in the grieving process as a way to conceptualize the relations between people and their worlds?

In this essay, I explore subjunctive grief as a methodology. In doing so, I am invested in articulating a method that resists the cognitive biases that many social science and humanistic methodologies embrace, as if rationality and rational decision making exist outside of the affective. Instead, tracking grief through the subjunctive is a means to highlight the role of affective connections in our lives and the ways that they shape individual and collective futures; it provides a method to conceptualize the affective attachments that people have to the future and past and how affect serves as a site to explore these relations.[14]

This essay is necessarily personal, as grief always is.[15] If grief is typically accepted as something that happens to us as a reaction to an emergent situation—the loss of a loved one, the betrayal of a friend, the failure of an institution to act ethically, the devastation of a weather event—subjunctive grief is an anticipatory process. Subjunctive grief asks us to imagine "what if?" and investigate how we can work with potentiality in the present as a means to alleviate concerns with change.[16] As a methodology, grief provides a focus on the connections between people and between people and their worlds by asking, "How would this change affect you? How would you miss this person, this place, this way of life?" Grief provides a webwork of care, both what people care about and who and what they care for, human and nonhuman, fleshy and not. But grief, like all emotions, is a cultural and individual system of priorities, and other methods rooted in emotions might be equally generative,[17] conceptualizing how, for example, anger or joy works to bind communities provides parallel lenses to draw relations, actors, and institutions together.[18] For me, grief, while not a universal human emotion, provides a foundation for a method that moves against normative assumptions about self-expression through language.[19] Grief can be expressed without words and accepted as an expression of connection between people and between people and things in ways that are accessible to the young and old, the disabled

and able-bodied, the neurotypical and neurodivergent.[20] In the following, I focus on two narratives about families as they struggle to make decisions about care for a family member. In both cases—one focused on medical aid in dying and the other on childhood psychosis (for lack of a better term)—family members wrestle with making the right decision based on a complex network of relations between people, between people and institutions, and between people and the forms of care they desire to have and provide. In their own ways, they confront experiences of inevitable change as the foundation for their decision making, and a conception of inexorable change grounds their experiences of grief as a necessary process to undergo—individually and collectively—by way of determining the ethical decision to make.

Invoking the ethical here is to gesture toward the possibility of a justice orientation that works to address the idiosyncrasies of individual and collective experience. The cases I present below might be construed as invoking "bioethical" concerns, as medical aid in dying has long been a site of political and philosophical debates in the United States and elsewhere and debates about institutionalized forms of care have long animated debates about psychiatry and the ethics of pharmaceuticalization.[21] But here I want to leave bioethics in the strict sense out of the frame, due to its reliance on principle, virtue, pragmatism, and utilitarian reason;[22] Instead, I want to draw on the affective to consider how it might serve as a counterpoint to positions that cast themselves as objective and rational.[23] In making this move to the affective, attention to the *feeling of justice* and its constant deferral[24] resonates with the subjunctivity of grief and attempts to mobilize the deferrals that disability communities address in seeking support for making and sustaining livable lives. What would it feel like to have one's access needs fully met?[25] To have one's personhood fully supported by communicative practices that allow for diverse forms of expression, such as sign language and other assistive technologies?[26] To have institutional support for forms of community that make lives more livable outside of disability's medicalization?[27] Anticipating a fully just world has the potential to surface experiences of grief,

particularly as one asks why that just world is impossible and what would need to occur to make it a reality. The subjunctive provides a space to imagine how justice might be enacted in the present and how it might inform the bioethical in ways that expand it to address the affective lives of the people bioethics captures.

The challenge in grief, which Freud identifies early on and which has been explored by those who followed him, is that in states of mourning, action becomes difficult. This is especially the case in the form of grief that he refers to as melancholia, which is characterized by its non-specific and generalized state; melancholia is akin to depression, a pervasive and seemingly unending lack of affect paired with a sense of inefficacy in the ability to change one's circumstances.[28] Mourning, contrariwise, is characterized by its sense of progression. While it is tempting to assert that ritual is important in mourning, including the standard practices of funeral rites,[29] ritual in the strict sense is less important than social commitment to grieving as a process, which aids in individual reintegration into society.[30] Mourning depends upon specificity and Freud describes it as the gradual acceptance of the loss, leading to the ability to form new attachments; he writes, "when the work of mourning is completed the ego becomes free and uninhibited again."[31] Mourning's power comes from its specificity, its ability to name what has changed and how it has changed. In this way, mourning is integral to subjunctive grief as a method, but it depends upon enacting mourning in the present—not because of a loss that has occurred, but with acceptance of changes that are or might be underway. Like a kinship chart demonstrating relational connections between individuals, subjunctive grief asks after the connections between people and their worlds—however they may be indexed or narrated—and how those connections animate people. In tracing those connections, subjunctive grief becomes a method to demonstrate the complex webs of vitality that sustain people. In the following, these connections become apparent through the emergence of something unexpected. In the first case, it propels a couple through a process of mourning in the present, as they confront a terminal illness; in the second, it captures a family in a state of protracted distress

and mourning until the mother comes to appreciate the nature of the risks they face as a family. They provide examples of people working through the "what if?" of the subjunctive and through this work they are able to make changes in the present that affect individual and collective futures.

Regimes of Inevitability

The "inevitability" of any process serves as the grounds for ethical decision making about it.[32] Processes that are inevitable cannot be acted upon in any meaningful way so as to alter their course, although attention might be paid to the effects of the process in order to mitigate its effects. Natural processes are generally ascribed degrees of agency that make them impossible for human action to mitigate,[33] and natural processes that humans undergo—from the daily wages of hunger and sleep to effects of aging—are afforded a degree of inevitability that can often only be acted upon by something suitably powerful, typically pharmaceutical chemicals. But even those chemicals reach a limit of effectiveness when held against the extremes of inevitable processes: eventually, days of hunger will result in organ failure; days of sleeplessness will result in uncontrolled sleep; aging will result in death; and terminal illnesses will likewise result in death. It is in this context that Americans have debated the ethical role of medically assisted death, sometimes referred to as physician-assisted suicide or, incorrectly, euthanasia, which is when the physician is solely responsible for the act of killing, rather than that decision being led by the patient. Proponents point to the inevitability of death and the parallel inevitability of "suffering" that will occur along the march toward death. Intense pain, loss of bodily volition, and dementia are all routinely cited as reasons to speed one's death through medical assistance. Many Americans support the practice—as of 2024, it was legal in eleven states—yet it is hotly contested by a minority of Americans who argue that it is human interference with divine inevitability (i.e., "only God can choose when a

person dies"), which points to the regimes of inevitability that structure its ethical contestation.

In addition, many disability activists argue against medical aid in dying, often citing the implicit ableism of the practice and the threat of creeping forms of coercion that incentivize killing disabled people over making their lives better through structural investments.[34] As examples of these kinds of critiques, the work of Not Dead Yet, a disability-based activist organization, and the work of Mary Johnson are illustrative. Not Dead Yet advocates call for opposition to the "legalization of assisted suicide," ensuring "that the withholding or withdrawal of life-sustaining medical treatment is truly voluntary," that "futility policies involving health care provider decisions to withhold or withdraw life-sustaining medical treatment" are opposed, and that "equal protection of the law in homicide cases when the victim is old, ill or disabled" is advocated for.[35] As Mary Johnson writes in *Ragged Edge*, surveying disability rights groups' responses to case of Terri Schiavo and the discontinuation of her life support,

> The only way disability bigotry of the "better dead than disabled" school has any chance of being stamped out–or even dislodged a bit–is if the disability rights movement is willing to speak forcefully and publicly about the tie-in between emerging public policies that in the guise of cost containment and choice in dying both promote futile care policies and define feeding tubes as "medical care," and the look-the-other-way stances of progressives and right-to-lifers alike as Medicaid is cut, healthcare services are cut, and anti-access judges are appointed to the federal branch.[36]

Johnson understands, much like the advocates in Not Dead Yet, that an inexorable slide towards a new eugenics through medical aid in dying is occurring, one that identifies individuals who do not meet the implicit standards of American neurotypicality as being "better dead than disabled." At the time of Schiavo's death in 2005, Diane Coleman, of Not Dead Yet, remarked that "The social presumption that [Schiavo] would be better off dead appears to have influenced

the decisions in this case. We feel threatened by this, almost as if there is a cognitive test for personhood under the law."[37] What Coleman feared in 2005 was a return to a eugenicist ideology motivated by a conception of disabled individuals as being unfit to live, which may be paired with forms of coercion that lead to euthanasia being masked as medical aid in dying—a situation not far removed from current debates in Canada and the US.[38] Because of these concerns about coercion, states where medical aid in dying laws have been enacted, like Oregon, have strict guidelines for determining if an individual is eligible for medical aid in dying based on cognitive capacity and consent.[39] Central to these debates are questions about "letting die" and "killing," which often skirt issues of self-determination, that many disability activists work to support.[40]

The way an individual narrates their choice to pursue medically assisted death reveals how they accept their abilities to act upon the future[41] and to grieve for the changes that they and their loved ones will undergo alongside their terminal illness and eventual death. One of the most public cases of medically assisted death is that of Brittany Maynard's, which occurred in 2014. Diagnosed with an aggressive brain cancer at 29, Maynard was originally given three to five years to live, predicated on successful treatment outcomes. After the removal of a significant amount of tumor, she was then re-diagnosed with an even more aggressive form of brain cancer, glioblastoma multiforme, and given just six months to live. Aware of "death with dignity" legislation in Oregon as the result of a college course she had taken, she and her newlywed husband moved from the Bay Area in California to Oregon so that she could avail herself of the life-ending medications she was entitled to as an Oregonian but which, at the time, were unavailable to her in California. The process required that she be independently diagnosed with a terminal illness by two doctors, be diagnosed as mentally fit, undergo a fifteen-day waiting period before requesting the drugs verbally and in writing, and then seek approval for a secobarbital prescription that would prove lethal. The drugs would be dispensed to her, but it would be up to her and her

partner, Daniel Diaz, to administer them when she chose to use them. Technically, she would need to administer them herself, in a glass of water mixed with the drugs, which obviated the possibility that someone else would administer the drugs to her against her will.

Throughout the process of seeking medical aid in dying, Maynard adopted the role of a public advocate for the process; she sought to make it possible for other families to avoid having to relocate to a distant state in order to avail themselves of the right and support for medical aid in dying. She recorded videos and posted them to YouTube and wrote editorials for national publications. Since her death, her widower has adopted this role of public advocate, partnering with the national advocacy group Compassion and Choices, and making media appearances—on podcasts, radio, and in Diane Rehm's documentary *When My Time Comes* (2021)—to promote legislation across the US in support of medical aid in dying. In his interview with Rehm, Diaz describes Maynard's experience balancing the impending physiological changes wrought by the cancer and its side effects with the fears associated with living in a society in which she is unable to end her life in the way that she wants to. He explains,

> She felt a lot of pressure at the base of her skull and neck . . . . By July, August, September, October . . . those last two months she was getting more and more uncomfortable. The seizures were what terrified her the most, and those became more frequent and more severe . . . The expression on her face became different because her muscles were contracting. The rest of her body would start to twitch—her arms, her legs . . . . She would usually be unable to speak or communicate at all or to write anything for maybe twenty or thirty minutes afterward. The sentences she would try to form wouldn't make any sense. Those were the mild seizures. The full grand mal seizures . . . were terrifying since on a couple of occasions, as she came out of the seizure and kind of regained consciousness, blood came out of her mouth because she'd bitten through part of her tongue.[42]

The danger Maynard perceived lay in the formulation of the medical aid in dying laws, which stipulated that she needed to self-administer the secobarbital that would end her life. If she was partially or completely paralyzed, she would be unable to do this, which would result in an end of life that she was hoping to avoid. She and Diaz accepted her impending death and the limitations she faced in relation to her changing body, but were committed to ensuring that they spent the last six months of their time together doing what they wanted: traveling, going for hikes and walks, and visiting with friends and relatives. Maynard accepted that doing this meant forgoing aggressive treatments of her cancer, knowing that undergoing treatment would inevitably have limited benefits and render her unable to participate in the activities that she wanted to prioritize, as she would be restricted to home or hospital during treatment.

Over these last months of her life, Maynard experienced the ups and downs of the remission and return of symptoms, and the everyday hope and dismay that come with living with a terminal illness. She had the support of her partner and family, the financial resources to relocate to Oregon, and the resources to navigate the medical systems in California and Oregon. The costs associated with her diagnosis, treatment, and ongoing care were significant and would make it impossible for a person of lesser means to accomplish what she and her partner were able to do. Diaz was able to arrange for leave from his employer, which came with partial pay. After they secured Maynard's medical aid in dying request, she narrated her experience as one of "relief." Even though she may "suffer" through her last months and days of life, she felt able to live while mourning; she was able to travel with her partner, advocate for medical aid in dying, and accomplish the goals she set for her last six months. She was motivated by the "would that we could live our lives together" without terminal cancer. This produced an impetus to live life as much as possible as unhindered by her dying through the use of the subjunctive. Her grieving the present was predicated upon her ability to narrate the changes that were occurring in the connections she prioritized, her

relationships with loved ones and her world, and how they will change with her advancing illness and death. Diaz explains,

> When she received approval for the medication, it provided her with an enormous sense of relief, a sense of having just a little bit of control in the midst of the chaos of a brain tumor. So much felt completely out of her control. Having the secobarbital allowed her to focus on life, because she no longer had to be so concerned about the dying process. It allowed her to do the things she wanted to do . . . . Her outlook from that point on was completely different. That fear was gone. She could now focus on living life, not being terrified to death.[43]

The removal of "fear" moves Maynard from a position of generalized despair toward mourning. As Diaz explains, she could "focus on living life," which allowed her to grieve her future changes through attending to the activities and relationships in her life that were more important than her dying. Being able to assert "control" over the inevitability of her dying and the limited future that cancer imposed on her and her relationships could, for Maynard, only be contested with her ability to control that death and its precise moment; she needed to bring the future into the present in order to motivate the actions she sought to undertake, both in advocating for her needs related to medical aid in dying and also in her relations with her loved ones. Some modicum of control of the future allows for a space in the present to accept the change that is occurring and the grieving that needs to occur in relation to that future, and it is this subjunctive space that is purposefully carved out against the inevitability of death through the social and material provisions of medical aid in dying policies.

Diaz goes on to explain the events that occurred during Maynard's final days, explaining how the intensity and regularity of her seizures increased to the degree that she feared the loss of the ability to consume the secobarbital, meaning that her ability to end her life would be forfeit and she would have to let death take its natural course, with its anticipated suffering. Maynard's goal became living through October in order to celebrate her and Diaz's wedding anniversary and his

birthday; they set November 1 as the day that she would end her life. Diaz explains, "During the last month of her life, the seizures were coming every four or five days. As the tumor continued to grow and put pressure on different parts of the brain, it would push on the optic nerve and she would lose her eyesight . . . . Partial paralysis was likely, complete paralysis a possibility. That's what Brittany was facing. And she said, 'I will not die that way.'"[44] He goes on to explain, "It's not that Brittany was choosing between living and dying. The living part was not on the table. The only thing Brittany was choosing between was two different ways of dying. One was gentle, the other would have been filled with pain and suffering . . . . She wanted to live. The brain tumor was ending her life."[45] In this way, Diaz and Maynard narrate their use of medical aid in dying as a choice that empowers them to live their lives as they want to, despite the inevitabilities of Maynard's cancer's progression. Subjunctive grief becomes possible in the acknowledgement of change, but its possibility as a practice of mourning depends on some facility of control over the inevitabilities of the future and what it will bring. Subjunctive grief asks, what might one do in the present to mitigate the affective inevitabilities on the horizon? Medical aid in dying is often cast in this way, creating a narrative structure for something that might otherwise feel out of control; in situations where control is elusive, it is less possible for grief to be articulated, as change seems impossible to acknowledge and work toward.

Maynard and Diaz are exemplary in their ability to face their grief head-on. Knowing they have a limited amount of time left together, they set about ensuring that the connections they find most important are brought to the fore. They collectively imagine the "would if I were dying" and together inhabit the space that is constructed between them with its revealed priorities. Amongst these, the ability to control Maynard's experience of death is primary, and once they have secured their ability to control the timing of her death, they engage in the activities and relationships that animate them. Maynard spends time with family and friends, travels to visit state and national parks throughout the US, and walks and hikes with her partner. That they are dislocated to Oregon to secure

Maynard's ability to access medical aid in dying is no small inconvenience, and it is precisely this that leads them to a place of advocacy for medical aid in dying across the US. A byproduct of this advocacy may be the ability for others to engage in a mourning practice like theirs, an enactment of subjunctive grief that brings the future into the present where it can serve as the basis of action and reflection.

Facilitating Monstrousness

I first heard Cheryl's story thanks to an episode of the NPR show *This American Life*, entitled "Bad Baby."[46] I have a distinct memory of listening to it while doing yard work, our first child in the house with my partner, his having recently turned three. Cheryl's family narrative is striking, which is captured in the brief interview she provides Ira Glass and is more developed in a blog she kept throughout 2014, myfamilymyvillage.com, that has since been abandoned but is archived through the Wayback Machine.[47] Cheryl narrates her experience as the mother of three children, two boys and a girl. The oldest of the children, eight at the time of the episode's recording, is extremely violent toward his brother and sister, having attempted to smother and drown his brother several times. He has aggressively thrown his little sister, who was cushioned by landing on a mattress. He has attacked his mother, giving her black eyes and a broken nose. His teachers and principal report that his behavior at school is disruptive in ways that they have not experienced with other students. His family regularly works with therapists, pediatricians, and psychiatrists, both in an effort to understand whether there is something about their family dynamics and parenting approach that leads the child to act in the way that he does and also to find means of mitigating his behavior, which leads them through various pharmaceutical treatments. The challenge for Cheryl and her family is that her oldest son seems impossible to change in any meaningful way, at least without heavy sedation, which removes his personality entirely. Whatever is the root cause of her eldest son's violent

behaviors and his apparent enjoyment of them, whether physiological (e.g., brain chemistry or an invisible impairment) or social (e.g., family dynamics or individual trauma), the behaviors seem unable to change. This has led experts to diagnoses of ADHD, conduct disorder, oppositional defiance disorder, mood dysregulation disorder, autism, and callous-unemotional, the last of which is sometimes accepted as a precursor to adult psychopathologies because it describes patterned disregard for the emotional experiences of others, aligning it with diagnoses of sociopathy and psychopathy.[48] Cheryl is put in the position of considering what she and her family can do to support her eldest son while also protecting themselves from his violence, particularly when his behavior is a constantly changing terrain of possibility.

Cheryl narrates their family experience, highlighting both her sense of her eldest child being "normal," and the inevitability of her eldest son's behavior, which they are unable to shape in ways that protect their family. He seems, to Cheryl, unperturbed by his attempt to kill his younger brother, and more troubled by being admonished by his mother for his actions.

> He was affectionate, seemed to be very attached to me. He seemed to be a normal child. I don't remember seeing a lot of aggression in him when he was littler . . . . And there was never any reason for his behavior. He just showed significant aggression towards me and towards his brother. And it was every day. When I look back, I realize that we've been walking on eggshells with this child since he was very little . . . . He decided to hold his brother under water in our backyard swimming pool. I was standing there about five feet away and felt some kind of commotion and turned around. And my son popped up out of the water, hysterical. My younger son popped up hysterical . . . . He did it and never acknowledged the danger of what he did. It never hits him that he could have killed his brother. It never seems to bother him that that was a possibility.[49]

Cheryl understands her eldest son as exhibiting a set of violent behaviors that exist beyond control; they are often spontaneous reactions to social interactions that he is having, which lead him to lash out at family members. Added to this, he

seems unreflexive about his behaviors and their impacts—physical, social, and emotional—on his family members. In these ways, he appears to meet the criteria for psychosis, his violent tendencies underwritten by a lack of compassion and social sensitivity. Cheryl finds her role as a mother—who must care for all of her children—to be troubled by her need to care for a child who puts his siblings and her at physical and emotional risk. She confronts this trouble by working through her understandings of her role as a mother and what it might become; she is buffeted by a sense of loss of her "normal child" and her need to find a way forward for her family amid the inevitabilities of his behaviors and their dangers.

In the following, Cheryl recounts her experience of parenting after her eldest son breaks her nose with his knee while she cuddles him on his bed. She draws attention to her experience of parenting as one that is based in a "natural" predilection for care for her children, which her eldest son's actions disturb. The trouble she faces is reconciling the need for providing him with "unconditional love"—as something that is scientifically prescribed[50]—and her inability to feel affectionate toward a child who behaves so callously.

> He has since tried to come into my bed, and he'll say I want to snuggle. "I want to snuggle." And it's something that I have to choose to do, because it's not a natural reaction any longer. I have to actually make the conscious decision to hug and love the child. I've read articles about children like him that their best chance at life is to continue to get that unconditional love, and so my husband and I make a concerted effort to grab him and hug him and love him, despite everything that we've been through. But I can tell you, as a parent, I had never expected to have to force myself to hug my child in the morning.

This last turn, "I had never expected to have to force myself to hug my child in the morning," is an index of Cheryl's grief. This experience of grief is predicated on her conception of the inevitable role of "nature" in supporting a maternal instinct which is suspended in relation to the inevitable nature of her eldest child's behavior. Two inevitable natures are pit against each other, and Cheryl's maternal

love buckles in the face of her child's seemingly intractable nature. Laminated onto this is what Cheryl increasingly accepts as a social inevitability: the need to send her eldest son to a residential facility where he can receive full time care in an effort to shape his behaviors while also protecting his family from his violent outbursts.

The solutions that Cheryl and her family are provided largely depend upon the medication of her eldest son, each of his diagnoses carrying the possibility of one or more pharmaceuticals that can be employed to manage his symptoms. Each of the pharmaceuticals also runs the risk of losing its efficacy or having an effect that is undesirable; the result is that her family is caught in an ongoing therapeutic relationship with pharmaceutical treatment that is functionally unable to resolve their concerns while also putting them at risk of their eldest son's violent behaviors. Cheryl provides this synopsis of their experience of 2014:

> Last year was hell. We had so many horrific episodes of life threatening, impulsive behavior. It was scary and still is. That's when the big gun meds started being added. The old stabilizers along with anti-anxiety, stimulant meds as well as non-stimulants meds, mood stabilizers and meds to sleep. At this point we were on our third psychiatrist because we couldn't get a psychiatrist that was available by phone and didn't take months to get back in to see. Unfortunately, during all this time, the explosive and abusive behavior at home only increased. By his fourth hospitalization (if you count the partial in-patient as a hospitalization) we had run the gamut from just ADHD and anxiety all the way to a ton of meds that included strong mood stabilizers like Depakote and Geodon. And yet the relief we sought for our family never came.[51]

The "relief" that Cheryl seeks is elusive both because of the shifting terrain of her son's behaviors and the changing efficacy of the pharmaceuticals they use. As she narrates, they rely on drugs throughout the day to manage her son's attention and violence and they depend on sedatives at night to help him sleep. The added complication is that they are also bouncing between health care providers, their need for specialists and people who are accessible chafing against their access to

care as provided through employer-based health care in the US. The result is that they are suspended between what her son might benefit from (pharmaceutically and socially), what their family needs, and what health care providers can supply them with, from new prescriptions to hypotheses regarding their family's challenges. After a series of short hospitalizations for her son in order to manage his behaviors, Cheryl faces the possibility of needing to send him to a residential hospital for a longer stay.

Cheryl struggles with a decision that she has to make about her eldest son's possible institutionalization. On one side, she accepts the need to care for her child—ideally in the home—yet, she understands that it is impossible to care for him and her other children, herself, and her husband, while he is in the home. On the other side, she accepts that sending him for a longer stay in a residential hospital might allow for expert care, both in relation to figuring out what pharmaceuticals would benefit him as well as providing him with the social and emotional support that might help him develop skills to manage his emotions at home. She explains the decision in terms of "the pain we would all suffer by sending him away" and her experience of "lost hope," two phrases that index her experience of grief:

> [The therapist's] hope with possible residential treatment is that we can have an intervention of sorts and potentially catch him while he's still young and impressionable and teach him how to at least respect other humans and to use his energy for good rather than to hurt. In theory, that would be amazing and worth the pain we would all suffer by sending him away. But after years of doctors, therapists, psychiatrists, psychologists, neurologists, hospitals and the shittiest mental health system around, I have lost hope.[52]

In the following, she pairs her experience of grief with her eldest son's emotional life. Foremost among the emotions she perceives in her son are his experiences of "sadness" and "anger," which she narrates as "morphing" him into a different state; and she is changing apace.

> The therapist said it's time to revisit longer term residential. The thought makes my skin crawl. But I look at my lil bear and I see his sadness. I see his anger. I see him morphing into a person that is suffering. And my heart is breaking. Piece by fragile piece. And then, for the first time, my [older] son got angry at his little sister and screamed at her and when she responded by throwing [a] cup at him, he hit her. Hard enough to make her cry and he wasn't sorry, it was her fault. And in that moment, that relationship clearly changed, right before my eyes.[53]

For Cheryl, this is the moment where she accepts that her indecision about her son's care needs to change; she asks, implicitly "what would happen if he were to stay in the home?, what would happen if he were to leave?" The clear and unwavering threat to her daughter puts her connections into stark relief: she is unwilling to lose her daughter to the violence of her eldest son. She moves from a state of generalized despair about their family life and toward the possibility of mourning; mourning the son she will lose in his moving out of the home, mourning the violent relationship between her children, mourning the changes to the children who will stay at home. In committing to some kind of change for her son and her family, she is able to narrativize a series of possibilities through the imaginative play of the subjunctive, including changes in her relationships and emotional commitments.[54] None of them may be desirable, but to ensure the safety of her children, her partner and herself, the changes must be made. And it is in their inevitability that the subjunctive becomes palpable. The necessity of things changing reveals the constraints that make the subjunctive space of play possible.

Ultimately, what decision Cheryl and her family makes is unclear. The "This American Life" story occurred relatively early in their family story, and she kept the blog until October 2014. In her last posts, she discusses their family life and its positive sides, expressing her gratitude for her partner and their family. Whether they decide to seek treatment for her son in a residential hospital is unstated, but her movement of emphasis away from discussing her eldest son and their family's challenges toward an attention to the family and its importance

to her can be read as a working through of the subjunctive: she works to identify what is in danger of change through the perpetuation of their family system with the eldest child in the home. Whether or not he is eventually sent to a residential hospital, Cheryl is now squarely in the realm of the subjunctive, working through her mourning in the present as she anticipates what might change in the future—and what the future will bring about for her child and family. If she ultimately chooses to not send her child away, she accepts a future of suffering that will bring about its own inevitabilities, and which will be mourned in turn.

The challenge that Cheryl and her family face is that they are trapped in a generalized state of despair. They are unsure of any possible future, with no clear trajectory. The threats to their family are weighed against her eldest son's psychiatric concerns, which freeze Cheryl in her decision making. As they move from one expert to another, there continues to be no clear way forward; the psychiatrists and physicians they consult can only offer a shifting set of recommendations with no sense of the inevitable trajectory her eldest son's life is wedded to, nor any sense of how that will affect their family. And in the face of lack of clarity, Cheryl and her family are unsure what to do. Yet, when her eldest son attacks her daughter, the changes the family need to confront are exposed: they must find a way forward that protects their daughter from their son's actions. This is likely the solution that residential treatment provides, with its attendant challenges for their family. But with that solution in place, they are able to begin planning—they can speculate on what her son's move to another home will entail for their family and can grieve the changes this will bring about. Snapping out of despair—in this case—is predicated on an emergent event; what happens next depends on the choices that Cheryl and her family make, the connections they seek to maintain and animate, and the care they seek to give and receive.

Conservativism as Anti-Grief

When I started to work through “subjunctive grief” as a concept, I immediately hit a few quandaries. Working against ideas about loss in disability studies and invoking the subjunctive provided a way to focus on change without casting change as necessarily predicated on loss in the strict sense. This reconfiguration of loss drew me to consider how environmental degradation was beginning to influence some discussions; as the climate changes, species will disappear as will particular landscapes, consumed by the ocean, baked in the heat, or burned due to increasing forest fires.[55] The impending loss of animal life and changing landscapes might be seen as similarly informing calls to appreciate the world as it is and come to terms with the changes that are coming due to governmental and corporate inaction. I also started to think about “race suicide” and its history within eugenics; as a term, it was first popularized in the early twentieth century as a way to alarm white Protestants about the birthrate of Catholics, who were construed as displacing the former. It has more recently been adopted by white supremacists to talk about the growing number of nonwhites in the US, Canada, and throughout Europe. If subjunctive grief felt appropriate to consider attitudes about environmental change, it felt wrong when applied to racists. Instead, I started to think about Didier Fassin’s discussion of *ressentiment* and resentment.[56] As Fassin recounts, for the political leadership in post-apartheid South Africa, a politics of *ressentiment* was vital, wherein the past and its harms can be acknowledged, which served as a means to articulate a shared future. In contrast, the politics of resentment framed the emergent experience of policing in France in the early 2000s. White police lashed out at members of immigrant and Black communities as an outgrowth of their anger about their sense of displacement at the heart of French society. Theirs was a rage borne of nostalgia for a racially pure past that never actually existed and an impossible mourning for something that never was and never will be. Rather than subjunctive grief for a changing social structure, they fueled racist acts through resentment born of

anger. This was presented—as many calls for a return to an imagined past are—as a response to loss; however, it was a performance of loss and grieving not intended to be resolved, but to stir up anger, hatred, denial, and violence. *Ressentiment*, alternatively, is kin to subjunctive grief, but it is weighed by the past; the subjunctive seeks to bring the future into the present, orienting perspectives toward the speculative rather than the historical. Where nostalgia might bar change or impose a future born of an imaginary past, the subjunctive invites change so as to create a space of speculative play that allows for coming to terms with the inevitable in a more liberatory fashion.

The work of subjunctive grief is to bring connections into relief. Doing so is not an uncomplicated process. Like Maynard and Diaz's confrontation with mortality through Maynard's cancer and terminal illness, or Cheryl's experience of love and kinship through her eldest son's violent behavior, it is often in periods of intensity that connections are made obvious and actionable. Yet, because of the trickery of grief, denial can operate in ways that obscure these connections. The result is that grief in the subjunctive becomes impossible because denial of change intercedes to interfere with the possibility of grief and the resolution that it can provide. Instead, individuals, families, and whole communities can become trapped in a state of despair, unable to accept what the future will bring, instead lashing out or retreating in the present. Maynard and Diaz are able to act in the present because they come to know the changes they face and seek ways to control those changes on their terms; Cheryl is trapped in her despair, faced with her feelings of love and obligation toward her children. It is only when she begins to confront the possibility of losing her daughter to the actions of her son that she shifts toward mourning. Tracing connections between people, people and things, people and institutions and environments, as people narrate change and its effects on their lives—particularly as it is expressed in their emotional connections—is a method of making the emergent actual. So often methodologies focus on what was. Orienting toward change, with all of the speculation it involves, has the potential to alter what critical methodologies might do, helping us reveal for

ourselves, and those we work with, the contours of our lives, the threats to them, and ways forward.

In these ways, affective methodologies might better describe the worlds we live in and the futures we imagine. In the days after Donald J. Trump's reelection to the US presidency in 2024, I found myself once again in despair for the future. Resurgent white supremacy now seemed like the least of the inevitable changes Americans faced: now he was to be joined with science and medicine skeptic, Robert F. Kennedy, Jr., and anti-labor, anti-regulatory, "free speech" proponent Elon Musk, while serving as a pawn for other corporate and authoritarian interests. I despaired for the lost opportunities to make meaningful climate change policies before even more radical changes to the environment might occur; I despaired at the likelihood of a misguided response to the next pandemic; the eroding protections for workers; the violence against immigrants; the list goes on. I despaired for my children, who would grow up in quickly eroding political and environmental landscapes. And then I realized that I had been in despair for all of 2023, with the Israeli assault on Palestinians, the ongoing conflict in Ukraine, the failures of the Biden administration to forward progressive legislation to protect women, workers, and marginalized communities. In that comparison I realized it was time to begin mourning; writing this is a first step in that process. There is no world of absolute justice, only justice-seeking; no liberation, only liberation-making. The subjunctive inspires the "would if we could" and its power lies in the collectivities that it makes possible and the spaces of play they enact. Rather than resist change because of the loss it evokes, as with nostalgic resentment, subjunctive grief allows for the possibility of working through affective attachments to a changing world, making way for a new collective reality that, if it is not just, inclusive, and equitable, is at least more just, more inclusive, and more equitable.

Notes

1. Lennard Davis, *Bending Over Backwards: Essays on Disability and the Body* (New York University Press, 2002); Alison Kafer, *Feminist, Queer, Crip* (Indiana University Press, 2013). ↩

2. H-Dirksen Bauman and Joseph Murray, eds., *Deaf Gain: Raising the Stakes for Human Diversity* (University of Minnesota Press, 2014); Arseli Dokumaci, *Activist Affordances: How Disabled People Improvise More Habitable Worlds* (Duke University Press, 2023); Michele Friedner, *Valuing Deaf Worlds in Urban India* (Rutgers University Press, 2015); Rosemarie Garland Thomson, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature* (Columbia University Press, 1996). ↩

3. Matthew Wolf-Meyer, *Theory for the World to Come* (University of Minnesota Press, 2019). ↩

4. Gilles Deleuze, *Spinoza: Practical Philosophy*, trans. by Robert Hurley (City Lights Books, 1988); Marilyn Strathern, "Cutting the Network," *Journal of the Royal Anthropological Institute* 2/3 (1996): 517–35, https://doi.org/10.2307/3034901 < https://doi.org/10.2307/3034901> . ↩

5. Sigmund Freud, "Mourning and Melancholia," in *On the History of the Psychoanalytic Movement: Papers on Metapsychology and Other Works 1914–1917*, trans. James Strachey, The Revised Standard Edition of the Complete Psychological Works of Sigmund Freud (Rowman & Littlefield, 2024), 212–31. ↩

6. Elizabeth Kubler-Ross and David Kessler, *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss* (Scribner, 2005). ↩

7. Renato Rosaldo, *Culture & Truth: The Remaking of Social Analysis* (Beacon Press, 1993); Charles Briggs, "Dear Dr. Freud," *Cultural Anthropology* 29, no. 2 (2014): 312–43, https://doi.org/10.14506/ca29.2.08 < https://doi.org/10.14506/ca29.2.08> . ↩

8. Viviane Green, "Grief in Two Guises: 'Mourning and Melancholia' Revisted," *Journal of Child Psychotherapy* 39, no. 1 (2013): 76–89, https://doi.org/10.1080/0075417X.2012.761424 < https://doi.org/10.1080/0075417X.2012.761424> ↩

9. Nicolas Abraham and Maria Torok, *The Shell and the Kernel: Renewals of Psychoanalysis* (University of Chicago Press, 1994). ↩

10. Marilyn Ivy, "Mourning the Japanese Thing," in *In Near Ruins: Cultural Theory at the End of the Century*, ed. Nicholas Dirks (University of Minnesota Press, 1998), 93–118; Zoe Wool, "Mourning, Affect, Sociality: On the Possibilities of Open Grief," *Cultural Anthropology* 35, no. 1 (2020): 40–47, https://doi.org/10.14506/ca35.1.06 < https://doi.org/10.14506/ca35.1.06> . ↩

11. Jody Messler Davies, “Reawakening Desire: Shame, Mourning, Analytic Love, and Psychoanalytic Imagination,” *Psychoanalytic Dialogues* 33, no. 3 (2023): 285–301, https://doi.org/10.1080/10481885.2023.2204773 < https://doi.org/10.1080/10481885.2023.2204773> .

12. Davies, “Reawakening Desire,” 293.

13. Davies, “Reawakening Desire,” 293, 297.

14. Lauren Berlant, *Cruel Optimism* (Duke University Press, 2011); Akemi Nishida, “Relating through Differences: Disability, Affective Relationality, and the U.S. Public Healthcare Assemblage,” *Subjectivity* 10, no. 1 (2017): 89–103, https://doi.org/10.1057/s41286-016-0018-2 < https://doi.org/10.1057/s41286-016-0018-2> ; J. Logan Smilges, “Cringe Theory,” *Lateral* 13, no. 1 (2024), https://doi.org/10.25158/L13.1.2 < https://doi.org/10.25158/L13.1.2> ; Alyson K. Spurgas, “Solidarity in Falling Apart: Toward a Crip, Collectivist, and Justice-Seeking Theory of Feminine Fracture,” *Lateral* 10, no. 1 (2021), https://doi.org/10.25158/L10.1.9 < https://doi.org/10.25158/L10.1.9> ; Kathleen Stewart, *Ordinary Affects* (Duke University Press, 2007).

15. Eva Kittay, “The Personal Is Philosophical Is Political: A Philosopher and Mother of a Cognitively Disabled Person Sends Notes from the Battlefield,” *Metaphilosophy* 40, no. 3–4 (2009): 606–27, https://doi.org/10.1111/j.1467-9973.2009.01600.x < https://doi.org/10.1111/j.1467-9973.2009.01600.x> .

16. Cf. Hirokazu Miyazaki, “Faith and Its Fulfillment: Agency, Exchange, and the Fijian Aesthetics of Completion,” *American Ethnologist* 27, no. 1 (2000): 31–51, https://www.jstor.org/stable/647125 < https://www.jstor.org/stable/647125> ; Karen-Sue Taussig, Klaus Hoeyer, and Stefan Helmreich, “The Anthropology of Potentiality in Biomedicine: An Introduction,” *Current Anthropology* 54, no. S7 (2013): S3–14). https://doi.org/10.1086/671401 < https://doi.org/10.1086/671401> .

17. Catherine Lutz and Geoffrey M. White, “The Anthropology of Emotions,” *Annual Review of Anthropology* 15 (1986): 405–36, https://doi.org/10.1146/annurev.an.15.100186.002201 < https://doi.org/10.1146/annurev.an.15.100186.002201> ; Richard Shweder, *Thinking Through Cultures: Expeditions in Cultural Psychology* (Harvard University Press, 1991).

18. Jean Briggs, *Never in Anger: Portrait of an Eskimo Family* (Harvard University Press, 1971); Jean L. Briggs, *Inuit Morality Play: The Emotional Education of a Three-Year-Old* (Yale University Press, 1999).

19. For example, Judith Butler, *Giving an Account of Oneself* (Fordham University Press, 2005); Antonio Damasio, *Self Comes to Mind: Constructing the Conscious Brain* (Random House Books, 2010).

20. Eli Clare, *Brilliant Imperfection: Grappling with Cure* (Duke University Press, 2017); Deborah Heath, Rayna Rapp, and Karen-Sue Taussig, “Genetic Citizenship,” in *A Companion to the Anthropology of Politics*, ed. David Nugent and Joan Vincent (Blackwell, 2005), 152–66; Rayna Rapp and Faye Ginsburg, “Enabling Disability:

Rewriting Kinship, Reimagining Citizenship," *Public Culture* 13, no. 3 (2001): 533–56, https://doi.org/10.1215/08992363-13-3-533 < https://doi.org/10.1215/08992363-13-3-533> .

21. M. L. Tina Stevens, *Bioethics in America: Origins and Cultural Politics* (Johns Hopkins University Press, 2000); Thomas Szasz, *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (Syracuse University Press, 1991).

22. Lisa Eckenwiler and Felicia Cohn, eds., *The Ethics of Bioethics: Mapping the Moral Landscape* (Johns Hopkins University Press, 2007).

23. Matthew Wolf-Meyer, "Neurological Disorders, Affective Bioethics, and the Nervous System: Reconsidering the Schiavo Case from a Materialist Perspective," *Medical Humanities* 46, no. 3 (2020): 166–75, https://doi.org/10.1136/medhum-2018-011568 < https://doi.org/10.1136/medhum-2018-011568> .

24. Jacques Derrida, "Force of Law: The 'Mystical Foundation of Authority," *Cardozo Law Review* 11, no. 5–6 (1990): 921–1045, https://larc.cardozo.yu.edu/clr/vol11/iss5/2 < https://larc.cardozo.yu.edu/clr/vol11/iss5/2> .

25. Mia Mingus, "Access Intimacy, Interdependence and Disability Justice," *Leaving Evidence*, 2017, https://leavingevidence.wordpress.com/2017/04/12/access-intimacy-interdependence-and-disability-justice < https://leavingevidence.wordpress.com/2017/04/12/access-intimacy-interdependence-and-disability-justice> ; Tanya Titchkosky, *The Question of Access: Disability, Space, Meaning* (University of Toronto Press, 2011).

26. Friedner, *Valuing Deaf Worlds*; E. Mara Green, "One Language, or Maybe Two: Direct Communication, Understanding, and Informal Interpreting in International Deaf Encounters," in *It's a Small World: International Deaf Spaces and Encounters*, ed. Michele Friedner and Annalies Kusters (Gallaudet University Press, 2015), 70–82.

27. Dokumaci, *Activist Affordances*.

28. Freud, "Mourning and Melancholia," 227; Julia Kristeva, *Black Sun: Depression and Melancholia* (Columbia University Press, 1989).

29. Shannon Lee Dawdy, *American Afterlives: Reinventing Death in the Twenty-First Century* (Princeton University Press, 2021); Richard Huntington and Peter Metcalfe, *Celebrations of Death: The Anthropology of Mortuary Ritual* (Cambridge University Press, 1979).

30. Butler, *Giving an Account*; Jean Langford, *Consoling Ghosts: Stories of Medicine and Mourning from Southeast Asians in Exile* (University of Minnesota Press, 2013).

31. Freud, "Mourning and Melancholia," 219.

32. Cf. John Martin Fischer and Mark Ravizza, "Responsibility and Inevitability," *Ethics* 101, no. 2 (1991): 258–78, https://www.jstor.org/stable/2381863 < https://www.jstor.org/stable/2381863> ; Susan R. Wolf, "Asymmetrical Freedom,"

Journal of Philosophy 77, no. 3 (1980): 151–60, https://www.jstor.org/stable/2025667 < https://www.jstor.org/stable/2025667> .

33. Sylvia Yanagisako and Carol Delaney, eds., *Naturalizing Power: Essays in Feminist Cultural Analysis* (Routledge, 1994).

34. Ben Colburn, "Disability-Based Arguments against Assisted Dying Laws," *Bioethics* 36 (2022): 680–86, https://doi.org/10.1111/bioe.13036 < https://doi.org/10.1111/bioe.13036> .

35. "Not Dead Yet's Goals," Not Yet Dead, accessed January 14, 2025, http://notdeadyet.org/about/goals.

36. Mary Johnson, "After Terri Schiavo: Why the Disability Rights Movement Spoke Out, Why Some of Us Worried, and Where Do We Go from Here?," 2005, http://www.raggededgemagazine.com/focus/postschiavo0405.html < http://www.raggededgemagazine.com/focus/postschiavo0405.html> .

37. Quoted in Johnson, "After Terri Schiavo."

38. Christopher Lyon, "Canada's Medical Assistance in Dying System Can Enable Healthcare Serial Killing," *HEC Forum*, 2024, https://link.springer.com/article/10.1007/s10730-024-09528-3 < https://link.springer.com/article/10.1007/s10730-024-09528-3> .

39. David Orentlicher, Thaddeus Mason Pope, and Ben A. Rich, "Clinical Criteria for Physician Aid in Dying," *Journal of Palliative Medicine* 19, no. 3 (2016): 259–62, https://doi.org/10.1089/jpm.2015.0092 < https://doi.org/10.1089/jpm.2015.0092> .

40. Doris Z. Fleischer and Freida Zames, *The Disability Rights Movement: From Charity to Confrontation* (Temple University Press, 2011); Carol Gill, "No, We Don't Think Our Doctors Are out to Get Us: Responding to the Straw Man Distortions of Disability Rights Arguments against Assisted Suicide," *Disability and Health Journal* 3, no. 1 (2010), https://doi.org/10.1016/j.dhjo.2009.10.003 < https://doi.org/10.1016/j.dhjo.2009.10.003> .

41. Mara Buchbinder, "Choreographing Death: A Social Phenomenology of Medical Aid-in-Dying in the United States," *Medical Anthropology Quarterly* 32, no. 4 (2018): 481–97, https://doi.org/10.1111/maq.12468 < https://doi.org/10.1111/maq.12468> .

42. Quoted in Diane Rehm, *When My Time Comes: Conversations About Whether Those Who Are Dying Should Have the Right to Determine When Life Should End* (Alfred A. Knopf, 2020), 43–44.

43. Quoted in Rehm, *When My Time Comes*, 45.

44. Quoted in Rehm, *When My Time Comes*, 46.

45. Quoted in Rehm, *When My Time Comes*, 49.

46. “Bad Baby,” *This American Life*, March 28, 2014, https://www.thisamericanlife.org/521/transcript < https://www.thisamericanlife.org/521/transcript> .

47. myfamilymyvillage, archived at https://web.archive.org/web/20140402051108/http://myfamilymyvillage.com < https://web.archive.org/web/20140402051108/http://myfamilymyvillage.com> .

48. R. James Blair, Ellen Leibenluft, and Daniel Pine, “Conduct Disorder and Callous-Unemotional Traits in Youth,” *New England Journal of Medicine* 371, no. 123 (2014): 2207–16, https://doi.org/10.1056/NEJMra1315612 < https://doi.org/10.1056/NEJMra1315612> .

49. “Bad Baby,” *This American Life*.

50. Cf. Nancy Scheper-Hughes, “Culture, Scarcity, and Maternal Thinking: Maternal Detachment and Infant Survival in a Brazilian Shantytown,” *Ethos* 13, no. 4 (1985): 291–317, https://doi.org/10.1525/eth.1985.13.4.02a00010 < https://psycnet.apa.org/doi/10.1525/eth.1985.13.4.02a00010> . In her study of infant mortality in the shanty towns of Brazil, Nancy Scheper-Hughes shows that maternal attachment is something that is withheld until children reach an age where they prove their ability to survive. Naming conventions follow suit, with children not being formally named until toddlerhood. Scheper-Hughes uses this example to argue that maternal attachment and maternal instincts are a by-product of post-World War II affluence in the North Atlantic; in precarious situations where children regularly die in infancy, mothers—and other family members—selectively attach to children. Scheper-Hughes uses this foundation to argue against the “nature” of maternal instinct, showing, instead, that that nature can be shaped to a variety of affective circumstances. See also my discussion in “‘Human Nature’ and the Biology of Everyday Life,” *American Anthropologist* 121, no. 2 (2019): 338–49, https://doi.org/10.1111/aman.13208 < https://doi.org/10.1111/aman.13208> .

51. “Med change – aaaagain,” myfamilymyvillage, September 30, 2014, archived at https://web.archive.org/web/20141002101144/http://www.myfamilymyvillage.com/ < https://web.archive.org/web/20141002101144/http://www.myfamilymyvillage.com/> .

52. “The new school year struggles,” myfamilymyvillage, September 17, 2014, archived at https://web.archive.org/web/20141002101144/http://www.myfamilymyvillage.com < https://web.archive.org/web/20141002101144/http://www.myfamilymyvillage.com> .

53. “The new school year struggles.”

54. Cheryl Mattingly, *Healing Dramas and Clinical Plots: The Narrative Structure of Experience* (Cambridge University Press, 1998).

55. Elizabeth Kolbert, *The Sixth Extinction: An Unnatural History* (Henry Holt and Company, 2014).

56. Didier Fassin, “On Resentment and Ressentiment: The Politics and Ethics of Moral Emotions,” *Current Anthropology* 54, no. 3 (2013): 249–67, https://doi.org/10.1086/670390 < https://doi.org/10.1086/670390> .

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